

Health Care Utilization Review: Potential Exposures to Negligence Liability

I. INTRODUCTION

Both public and private health insurers have struggled in recent years to find ways to control the rising costs of health care.¹ One of the most widely adopted methods that insurers have turned to is utilization review. Utilization review can be defined as “[e]valuation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities.”² Insurers, trying to control costs, use utilization review to evaluate claims on a case-by-case basis. If, after a claim has been reviewed, the insurer believes that the medical care given or proposed is not necessary or appropriate to the treatment of the patient, the insurer will deny payment of the claim on the grounds that it is not “medically necessary.”³

Utilization review can be either retrospective or prospective. In retrospective utilization review, the review of the claim comes *after* the care has been given. Therefore, while a retrospective payment denial may lead to heated disputes over who will pay the doctor or hospital, it usually does not have a significant impact on the patient’s care.⁴

Under prospective utilization review, however, the review of the patient’s claim comes *before* the care is to be given. Thus, when the insurer denies a

¹ Although health care costs have traditionally grown faster than the general rate of inflation (U.S. health care expenditures as a percentage of the Gross National Product (GNP) nearly doubled between 1965 and 1987), the growth of health care costs has become particularly alarming in recent years. For instance, total health care spending grew from \$324 billion to \$500 billion just from 1982 to 1987. See Levit, Freeland, & Waldo, *Health Spending and Ability to Pay: Business, Individuals, and Government*, HEALTH CARE FINANCING REV., Spring 1989, at 1, 3.

² T. TIMMRECK, DICTIONARY OF HEALTH SERVICES MANAGEMENT 613 (2d ed. 1987).

³ The term “medical necessity” is widely used in the utilization review industry, but it may be used differently by different organizations. Some may use it narrowly to refer to the *clinical need* for a procedure, whereas others may use it to refer to both *clinical need* (necessity) and *appropriateness*. INSTITUTE OF MEDICINE, CONTROLLING COSTS AND CHANGING PATIENT CARE? THE ROLE OF UTILIZATION MANAGEMENT 18 (1989).

⁴ It has been pointed out that retrospective denial of payment “will save money for the third party, but without warning will divert the cost to the patient or hospital.” Zusman, *Utilization Review: Theory, Practice, and Issues*, 41 HOSP. & COMMUNITY PSYCHIATRY 531, 534 (1990). Therefore, while retrospective utilization review might reduce costs on an individual payor level, it is generally unsatisfactory as a cost containment device on a broader, societal level. The care has already been given by the time review is undertaken, and the question at that time is not *whether* the care will be paid for, but *who* will pay.

claim, the patient is told up front that his insurance company will not pay for the proposed care, and that he must pay for the care out of his own pocket if he wishes to receive it.⁵

The patient may, of course, still go ahead with the treatment. However, he may decline to do so, either because he cannot afford to pay for the treatment himself or because he feels that the burden of paying for the treatment himself outweighs its benefit to him. Having foregone the proposed treatment, the patient may subsequently suffer some harm. If the utilization review organization's denial of payment was negligent and its negligence was the cause of the patient's harm, the patient may have a cause of action against the organization. The issue, therefore, is this: When, and under what circumstances, can a utilization review organization's denial of payment be said to have negligently harmed a patient?

This Note will examine the potential negligence liability of third-party payors who use prospective utilization review as a means of controlling their health care costs. It will first discuss the cause of action of negligence and the special problems courts may encounter in applying it to the context of utilization review. Next, it will discuss in detail the two leading California cases that have dealt with the issue of negligent utilization review. Then, it will address the issue of direct versus indirect liability for negligent utilization review. Finally, the Note will look at potential barriers to utilization review liability.⁶

II. THE CAUSE OF ACTION

The cause of action of negligence consists of four basic elements. They are:

⁵ Two of the more common forms of prospective utilization review are preadmission review and concurrent review. Preadmission review for elective inpatient procedures allows the reviewer to examine proposed hospital admissions for "medical necessity" before the patient is admitted. Concurrent review, on the other hand, allows the reviewer to assess "the length of stay for both urgent and nonurgent admissions" while the patient is in the hospital. INSTITUTE OF MEDICINE, *supra* note 3, at 18.

⁶ The focus of this Note is limited to the potential *negligence* liability resulting from utilization review denials of payment. Keep in mind, however, that enterprising attorneys may be able to hold utilization review organizations liable on other theories as well. *See, e.g., Hughes v. Blue Cross of N. California*, 215 Cal. App. 3d 832, 845-46, 263 Cal. Rptr. 850, 856-57 (1989) (insurer breached implied covenant of good faith and fair dealing by denying benefits when it employed a standard of medical necessity "significantly at variance with the medical standards of the community" in conducting its review and when it failed to properly investigate its insured's claim).

1. A duty recognized by law that requires the defendant to conform to a certain standard of conduct;
2. A breach of that duty, or a failure to conform to the standard;
3. A causal connection between the breach and the plaintiff's injury; and,
4. An actual loss or injury to the plaintiff.⁷

Actual loss or injury and breach of duty, once a duty has been established, are matters of fact to be proven by the plaintiff at trial and are therefore relatively straightforward. However, the other two elements, the existence of a duty and a causal connection between the breach of duty and the injury, present certain conceptual difficulties when applied to third-party utilization decisions.

The element of duty can be broken down into two components. The first is the question of whether a duty exists at all: Do third-party utilization review organizations owe a duty of care to the patients whose claims they review? It has been said that "courts will find a duty where, in general, reasonable persons would recognize it and agree that it exists."⁸

The question of the existence of a duty is sometimes discussed in terms of foreseeability of harm.⁹ As noted above, patients whose claims for treatment have been denied may very well decide against receiving the treatment. If the treatment does turn out to have been medically necessary, then the potential for injury to the patient is clearly "foreseeable." Therefore, it is reasonable to assume that "courts will almost certainly find that payors owe a duty to their beneficiaries to perform utilization review programs with due care."¹⁰

The second component of the element of duty is that of the standard of care: What is the nature of the standard of care to which utilization review organizations should be held? Two related standards of care have been suggested. First, utilization review organizations could be held to a standard of care in the design and implementation of their review programs (a procedural standard).¹¹ This procedural standard presumably would be based on acceptable practice among the general community of review organizations.¹² Several sets of suggested utilization review practices have been proposed with the intent to improve review quality and reduce potential liability exposure in

⁷ W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON THE LAW OF TORTS 164-65 (5th ed. 1984) [hereinafter PROSSER & KEETON].

⁸ *Id.* at 359.

⁹ Helvestine, *Legal Implications of Utilization Review*, in CONTROLLING COSTS AND CHANGING PATIENT CARE? THE ROLE OF UTILIZATION MANAGEMENT 169, 175 (Institute of Medicine, 1989).

¹⁰ Jespersen & Kendall, *Utilization Review: Avoiding Liability While Controlling Costs*, HEALTHSPAN, July 1987, at 3, 4.

¹¹ Helvestine, *supra* note 9, at 176.

¹² *Id.*

the utilization review industry, and they could be helpful in determining the procedural standard.¹³

Second, utilization review organizations could be held to a standard of care in their determination of medical necessity (a medical standard).¹⁴ As utilization review organizations "at least implicitly hold themselves out as having special skill in the evaluation of medical treatment,"¹⁵ the medical standard should be that of accepted medical practice.

The element of causation can also be broken down into two components. One concerns whether there is a sufficient causal connection between the denial of payment for treatment and the harm resulting from the foregoing of that treatment. In other words, is the denial of payment the *proximate cause* of the patient's harm? As the matter has been stated, "[s]trictly speaking, [a utilization review organization's] determination of a lack of medical justification for services affects only payment by the health insurer or other third party. The determination *does not preclude the provider from rendering the proposed services* if the patient desires them."¹⁶ If the decision to forego treatment—a *clinical* decision made by the patient and his physician—cannot be linked to the denial of payment—a *financial* decision made by the review organization, then the denial of payment by the review organization cannot be the proximate cause of the patient's harm.

Of course, the above discussion assumes that the patient would not have suffered the harm if he had received the treatment. This leads to the second component of causation, *causation in fact*. As in an ordinary medical malpractice case, the patient must prove that the proposed treatment would have prevented the harm suffered from occurring, or the review organization will not be liable as it is not the cause in fact of the patient's injury.¹⁷

III. THE CASES

Two leading cases, both decided in the state of California, deal with the potential negligence liability of third-party utilization review organizations. In

¹³ See Jespersen & Kendall, *supra* note 10, at 7; Hinden & Elden, *Liability Issues for Managed Care Entities*, 14 SETON HALL LEGIS. J. 1, 56-58 (1990).

¹⁴ Helvestine, *supra* note 9, at 176.

¹⁵ Jespersen & Kendall, *supra* note 10, at 4.

¹⁶ Hershey, *Fourth-Party Audit Organizations: Practical and Legal Considerations*, 14 LAW, MED. & HEALTH CARE 54, 62 (1986) (emphasis added).

¹⁷ Consider the following: The patient suffers *irreversible* brain damage in a fall and eventually dies. The defendant physician is clearly negligent in failing to diagnose the patient's skull fracture. However, the physician is not held liable because the plaintiff cannot show that the patient would have lived had the doctor diagnosed the skull fracture and treated the patient accordingly. *Neal v. Welker*, 426 S.W.2d 476 (Ky. Ct. App. 1968), *cited in* D. HARNEY, *MEDICAL MALPRACTICE* 165 (1973).

1986, a California Court of Appeals in *Wickline v. State of California*¹⁸ became the first court to address the issue, holding that utilization review organizations may be held liable for negligence in some situations. Although its determination of the scope of liability was fairly narrow, the case caused great concern in the insurance and utilization review industries and was widely discussed.¹⁹

Wickline remained the most important case to address the issue of utilization review organization liability until 1990, when the same California Court of Appeals decided *Wilson v. Blue Cross of Southern California*.²⁰ The court in *Wilson* expanded the potential liability of utilization review organizations, taking great pains to distinguish the case from *Wickline* in doing so and causing even greater concern in the insurance and utilization review industries. The following section of this Note will examine the *Wickline* and *Wilson* cases, paying particular attention to how they handle the issues of duty and causation, in order to get a sense of the development of this emerging area of liability.

A. *Wickline v. State of California*

1. *The Facts*

Lois J. Wickline was being treated by her family physician for problems with her back and legs.²¹ Because she was not responding to his treatment, her doctor called in a vascular surgeon who determined that the problem was circulatory and that an operation was necessary.²² Since Wickline was covered under Medi-Cal, California's Medicaid program, her family doctor submitted a treatment authorization request to Medi-Cal as provided for by statute.²³ Medi-Cal authorized payment for the surgery and ten days of hospitalization.²⁴

The vascular surgeon, assisted by a second surgeon, performed the operation. Wickline's recovery was "stormy," however, and she experienced complications which required the surgeons to perform two more operations.²⁵

¹⁸ 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (1986).

¹⁹ See, e.g., Note, *Provider Liability Under Public Law 98-21: The Medicare Prospective Payment System in Light of Wickline v. State*, 34 BUFFALO L. REV. 1011 (1985); Schanz, *Wickline v. State of California: Closing the Door of Third-Party Payor Liability?*, 22 TORT & INS. L.J. 331 (1987).

²⁰ 222 Cal. App. 3d 660, 271 Cal. Rptr. 876 (Ct. App. 1990).

²¹ *Wickline*, 192 Cal. App. 3d at 1634, 239 Cal. Rptr. at 812.

²² *Id.* at 1634-35, 239 Cal. Rptr. at 812.

²³ *Id.* at 1635, 239 Cal. Rptr. at 812.

²⁴ *Id.*

²⁵ *Id.*

Because of the complications, Wickline's doctors requested Medi-Cal to authorize payment for an additional eight days of hospitalization, so that she could be observed and treated immediately if further complications arose.²⁶ However, based on the information contained in her doctors' request, the Medi-Cal consultant authorized payment for only four additional days. Wickline's doctors subsequently discharged her from the hospital after the additional four days without appealing the Medi-Cal consultant's decision.²⁷

After her discharge, Wickline experienced progressive pain and discoloration in her right leg. On the ninth day after her discharge, Wickline was readmitted to the hospital as an emergency patient, therefore not requiring prior authorization of payment.²⁸ Upon examination, her doctors discovered clotting and infection in the incision which ultimately led to the amputation of her right leg.²⁹

Wickline then sued Medi-Cal, claiming that it was negligent in not authorizing payment for the full eight day extension requested by her doctors, and that its denial of payment subsequently caused her to lose her leg.³⁰ The trial court awarded her five hundred thousand dollars,³¹ but the court of appeals reversed, holding that Medi-Cal, in this particular case, was not liable as a matter of law.³² However, the court of appeals also noted that "[t]he patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, *including, when appropriate, health care payors.*"³³

2. Duty

The court in *Wickline* answered the question of whether utilization review organizations owe a duty of care to the patients whose claims they review by citing section 1714 of the California Civil Code³⁴ and the case of *Rowland v. Christian*.³⁵ Section 1714 of the Civil Code states that "[e]very one is

²⁶ *Id.* at 1636, 239 Cal. Rptr. at 813.

²⁷ *Id.* at 1637-39, 239 Cal. Rptr. at 814-15.

²⁸ *Id.* at 1640-41, 239 Cal. Rptr. at 816.

²⁹ *Id.* at 1641, 239 Cal. Rptr. at 816-17.

³⁰ *Id.* at 1633, 239 Cal. Rptr. at 811. Wickline did *not* sue her own doctors. It has been reported that this was because "[s]he felt they were victims of the system, as she herself had been." Carlova, *A Jury Lands a \$500,000 Haymaker on Health Bureaucrats*, MED. ECONOMICS, May 16, 1983, at 80, 83.

³¹ Carlova, *supra* note 30, at 85.

³² *Wickline*, 192 Cal. App. 3d at 1647, 239 Cal. Rptr. at 820.

³³ *Id.* at 1645, 239 Cal. Rptr. at 819 (emphasis added).

³⁴ CAL. CIV. CODE § 1714 (West 1985).

³⁵ 69 Cal. 2d 108, 70 Cal. Rptr. 97, 443 P.2d 561 (1968).

responsible, not only for the results of his willful acts, but also for an injury occasioned to another by his want of ordinary care or skill in the management of his property or person. . . .”³⁶ The California Supreme Court in *Rowland v. Christian* rephrased this section, stating that “[a]ll persons are required to use ordinary care to prevent others being injured as a result of their conduct.”³⁷

Going further, the *Rowland* court also noted that “in the absence of statutory provision declaring an exception to the fundamental principle enunciated by section 1714 of the Civil Code, no such exception should be made unless clearly supported by public policy.”³⁸ Therefore, the court in *Wickline* seems to be saying that utilization review organizations, just like everyone else, generally owe a duty of care to patients unless a statute or policy supports an exception to the duty. The court did not discuss the issue further, as it ultimately based its decision on the issue of causation.

With regard to the standard of care to which utilization review organizations should be held, the court in *Wickline* clearly contemplates that review organizations should be held to a procedural standard of care, as it states that:

[t]hird party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost-containment mechanisms as, for example, when appeals made on a patient’s behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.³⁹

The court did discuss the testimony given at trial regarding the procedures followed by Medi-Cal both in general and in *Wickline*’s case. By not criticizing these procedures, the court at least implicitly accepted them as being adequate.⁴⁰ Unfortunately, however, it did not reveal the standard against which it measured the Medi-Cal procedures because, as noted above, its decision rested on other grounds.

As to the medical standard of care, the court noted that Title 22 of the California Administrative Code, which governs Medi-Cal, provided that “[t]he determination of need for acute care shall be made in accordance with the usual standards of medical practice in the community.”⁴¹ Therefore, a medical

³⁶ CAL. CIV. CODE § 1714 (West 1985).

³⁷ *Rowland*, 69 Cal. 2d at 112, 70 Cal. Rptr. at 100, 443 P.2d at 564.

³⁸ *Id.*

³⁹ *Wickline v. State*, 192 Cal. App. 3d 1630, 1645, 239 Cal. Rptr. 810, 819 (1986).

⁴⁰ *Helvestine*, *supra* note 9, at 176.

⁴¹ The court of appeals construed the California Administrative Code as it existed at the time of *Wickline*’s injury; the section in question had been amended between the time of *Wickline*’s injury and the time her case was heard by the court of appeals. CAL. ADMIN.

standard of care was imposed on Medi-Cal by regulation. Because all of the expert witnesses at the trial testified that the discharge of Wickline after only four additional days was "within the standards of practice of the medical community," the appellate court could reasonably conclude that the denial of payment met accepted medical practice (although it did not make this point explicitly).⁴² On the other hand, the *Wickline* court did not directly discuss the issue of whether utilization review organizations generally should be held to a medical standard of care in their determinations of medical necessity.

3. Causation

Ultimately, the court's determination in *Wickline* that Medi-Cal was not liable was based on lack of causation; the court decided that Medi-Cal was not the proximate cause of Wickline's injury. The *Wickline* court framed the issue of proximate cause in terms of determining "who bears responsibility for allowing a patient to be discharged from the hospital. . . ."⁴³ The court found that the responsibility to discharge rests with the patient's own physician, reasoning that if, in his medical judgment, Wickline required further hospitalization, her doctor "should have made some effort to keep her" in the hospital.⁴⁴ However, the court found that *her own doctor's* medical judgment was to discharge her, and that "Medi-Cal was not a party to that medical decision and therefore cannot be held to share in the harm resulting if such decision was negligently made."⁴⁵ In the court's view, the discharge decision rests with the physician, independent of the utilization review determination, so that denial of payment cannot be the proximate cause of the patient's harm. As a result, the court held that Medi-Cal was not liable as a matter of law.

One factor that the court found significant in deciding *Wickline* was the fact that none of her doctors appealed the Medi-Cal payment denial, although they all knew that they could do so.⁴⁶ The court felt that physicians have a duty to appeal payment denials on behalf of the patient when they disagree with the reviewer's determination of medical necessity.⁴⁷ According to the court, the failure of Wickline's doctors to appeal the denial implied agreement with it, so

CODE § 51110 (West 1983), cited in *Wickline*, 192 Cal. App. 3d at 1645, 239 Cal. Rptr. at 819.

⁴² *Wickline*, 192 Cal. App. 3d at 1640, 239 Cal. Rptr. at 816.

⁴³ *Id.* at 1644, 239 Cal. Rptr. at 819.

⁴⁴ *Id.* at 1645, 239 Cal. Rptr. at 819.

⁴⁵ *Id.* at 1646, 239 Cal. Rptr. at 819.

⁴⁶ *Id.* at 1639, 239 Cal. Rptr. at 815.

⁴⁷ The view that physicians should act as "advocates" for their patients when dealing with third-party payors and reviewers has been expressed in recent literature. See, e.g., Furrow, *The Ethics of Cost Containment: Bureaucratic Medicine and the Doctor as Patient Advocate*, 3 NOTRE DAME J. LAW, ETHICS & PUB. POL. 187 (1988).

that the Medi-Cal payment denial could not be said to have corrupted their medical judgment.⁴⁸ However, the court left open the possibility that it might be more willing to find proximate cause in cases where the patient's physician appealed a payment denial and the appeal was also denied. The court's statement of the applicable law said only that "the physician who complies *without protest* with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care."⁴⁹

There was also some dispute in *Wickline* as to causation in fact; that is, whether Wickline would not have lost her leg if she had remained hospitalized the full eight additional days.⁵⁰ Although her surgeon testified that, in his opinion, she would not have lost her leg if she had remained hospitalized, her family doctor testified that he saw her in his office one week after her discharge, at which time she would have been home even if the full hospitalization request had been granted, and he had not seen anything unusual.⁵¹ Therefore, the denied hospitalization for observation might not have prevented the loss of Mrs. Wickline's leg.

B. Wilson v. Blue Cross of Southern California

1. *The Facts*

On March 1, 1983, Howard Wilson Jr. admitted himself to the hospital, suffering from "major depression, drug dependency, and anorexia."⁵² Wilson's physician believed that Wilson required three to four weeks of hospitalization. However, on March 11, 1983, Western Medical Review, the utilization review organization responsible for reviewing Wilson's claim, informed his doctor that Wilson's hospitalization was "not justified or approved" and that payment for further hospital care would not be made.⁵³ Wilson's doctor believed that Wilson "required further in-patient treatment," but the doctor did not appeal Western Medical's determination. Instead, he informed Wilson that "he (Wilson) would 'not be covered financially by his insurance company and that the liability [for hospital costs] would then be his.'"⁵⁴ Wilson was not happy with the decision, but he had to leave the hospital because, according to his aunt, "the family did not have enough money to pay for the cost of in-patient

⁴⁸ *Wickline*, 192 Cal. App. 3d at 1646-47, 239 Cal. Rptr. at 819-20.

⁴⁹ *Id.* at 1645, 239 Cal. Rptr. at 819 (emphasis added).

⁵⁰ *Id.* at 1642, 239 Cal. Rptr. at 817.

⁵¹ *Id.*

⁵² *Wilson v. Blue Cross of S. California*, 222 Cal. App. 3d 660, 663, 271 Cal. Rptr. 810, 877 (1990).

⁵³ *Id.* at 669-70, 271 Cal. Rptr. at 882.

⁵⁴ *Id.*

hospitalization.”⁵⁵ Subsequently, on March 31, 1983, Wilson committed suicide.⁵⁶

Wilson's parents then filed suit against Blue Cross and Blue Shield of Alabama (who covered Wilson), Blue Cross of Southern California (to whom Blue Cross and Blue Shield of Alabama had delegated the administration of claims, including Wilson's), Western Medical Review (who had contracted with Blue Cross of Southern California to perform utilization review), and the Western Medical physician reviewer who handled Wilson's claim.⁵⁷ Alabama Blue Cross, Western Medical, and the Western Medical physician all filed summary judgment motions, arguing that, under *Wickline*, the decision to discharge Wilson was the sole responsibility of his doctor, that public policy considerations warrant an exemption for utilization review organizations from the general rule of liability, and that Wilson's doctor had a duty to protest the decision which he failed to carry out.⁵⁸

The trial court granted the summary judgment motions, and the Wilsons appealed.⁵⁹ The court of appeals reversed, holding that there were triable claims, and remanded the case back to the trial court.⁶⁰ In doing so, the court of appeals stated that “*Wickline* should be limited to its facts and the legal issues properly decided in that case. . . .”⁶¹ As a result, much of the discussion of duty and causation in *Wilson* consists of refinement, reinterpretation, or limitation of the discussion of those issues in *Wickline*.

2. Duty

In filing their summary judgment motions, the defendants raised only the first of the two components of duty discussed earlier in this Note,⁶² the question of the existence of a duty. Therefore, only the existence of a duty (and not the issue of the standard of care) is discussed in *Wilson*. Both the *Wilson* court and the defendants accepted the basic proposition set forth in *Wickline*: Utilization review organizations owe a duty of care to the patients whose claims they review unless they are relieved of that duty by a statutory or policy exemption.⁶³ The defendants, therefore, argued that they were entitled to a

⁵⁵ *Id.*

⁵⁶ *Id.* at 664, 271 Cal. Rptr. at 878.

⁵⁷ *Id.* at 667, 271 Cal. Rptr. at 880.

⁵⁸ *Id.* at 671-74, 271 Cal. Rptr. at 883-85.

⁵⁹ *Id.* at 664, 271 Cal. Rptr. at 878.

⁶⁰ *Id.* at 674-75, 271 Cal. Rptr. at 885.

⁶¹ *Id.* at 664, 271 Cal. Rptr. at 878.

⁶² See *supra* notes 8-10 and accompanying text.

⁶³ The court of appeals in *Wilson* discusses the analysis of duty in *Wickline* dealing with section 1714 of the California Administrative Code and *Rowland* with seeming

policy exemption because "there are important public policy considerations which warrant protecting insurance companies and related entities which conduct concurrent utilization review."⁶⁴

The *Wilson* court disagreed. First of all, the court noted that Medi-Cal's duty to provide funds was governed by "statutes and regulations [which] altered the normal course of tort liability . . . [by permitting] the state to deny Medi-Cal benefits when to do so was 'in accordance with the usual standards of medical practice in the community.'"⁶⁵ In other words, Medi-Cal had a statutory exemption to the duty of care which it in fact met, as the discharge in *Wickline* was within accepted practice. The defendants in *Wilson*, however, were private insurers, and had no such statutory exemption.⁶⁶

Second, the court stated that "the normal basis of tort liability can only be departed from when 'public policy *clearly* requires that an exception be made.'"⁶⁷ In the court's view, the statutes and regulations governing Medi-Cal expressed a clear public policy in *Wickline*, but the defendants in *Wilson* had "no similar clearly expressed public policy"⁶⁸ Therefore, the court in *Wilson* found that the defendants were subject to the ordinary duty of care.

3. Causation

The defendants in *Wilson* argued that they were not liable as a matter of law because, under *Wickline*, "when a treating physician makes a decision to discharge a patient because an insurance company refuses to pay benefits . . . the sole liability rests with the [patient's] physician."⁶⁹ As noted previously, this is because the *Wickline* court considered the denial of payment to have no part in the discharge decision itself, and therefore payment denial could not be the proximate cause of the patient's harm.⁷⁰

The *Wilson* court discarded this view, taking a different approach to the issue of causation. First, the court in *Wilson* dismissed the language in *Wickline* stating that "the physician . . . cannot avoid his ultimate responsibility for his patient's care" as dicta which was "unnecessary to the decision"⁷¹ This is

approval, and the defendants did not dispute it. *Wilson*, 222 Cal. App. 3d at 671-74, 271 Cal. Rptr. at 883-85.

⁶⁴ *Id.* at 672, 271 Cal. Rptr. at 884.

⁶⁵ *Id.* at 665-66, 271 Cal. Rptr. at 879 (citing *Wickline v. State*, 192 Cal. App. 3d 1630, 1645, 239 Cal. Rptr. 810, 819 (1986)).

⁶⁶ *Wilson*, 222 Cal. App. 3d at 665-66, 271 Cal. Rptr. at 879.

⁶⁷ *Id.* at 673, 271 Cal. Rptr. at 884, (citing *Lipson v. Superior Court*, 31 Cal. 3d 362, 372, 182 Cal. Rptr. 629, 636, 644 P.2d 822, 829 (1982) (emphasis added)).

⁶⁸ *Wilson*, 222 Cal. App. 3d at 673, 271 Cal. Rptr. at 884.

⁶⁹ *Id.* at 671, 271 Cal. Rptr. at 883.

⁷⁰ See *supra* notes 43-45 and accompanying text.

⁷¹ *Wilson*, 222 Cal. App. 3d at 666-67, 271 Cal. Rptr. at 879-80.

surprising, as this language had seemed to be the basis of the court's decision in *Wickline*. However, the court in *Wilson* stated that the "legitimate rationale" of *Wickline* was that Medi-Cal was governed, not by the ordinary rules of liability, but by a statutory standard of duty (to determine payment in accordance with accepted medical practice) to which it did in fact conform (the payment denial was within accepted medical practice).⁷² Given that basis for deciding *Wickline*, the broad statement that liability rests solely with the physician becomes unnecessary and superfluous.

Second, the *Wilson* court dismissed the proposition that liability for discharge decisions rests solely with the patient's physician on the grounds that it "misconstrues the test for joint liability for tortious conduct."⁷³ For the correct proposition of law, the court turned to section 431 of the Restatement (Second) of Torts, which states that "[t]he actor's negligent conduct is a legal cause of harm to another if . . . his conduct is a *substantial factor* in bringing about the harm"⁷⁴ After asserting that the Restatement provision "correctly states California law as to the issue of causation in tort cases,"⁷⁵ the court examined the facts in *Wilson* to determine if the substantial factor test had been met. First, the court noted that "[o]nce the insurance benefits were terminated, there were no other funds to pay for [Wilson's] hospitalization," and that this lack of funds was "[t]he sole reason for the discharge"⁷⁶ Unlike *Wickline*, the *Wilson* court had no problem linking the denial of payment to the discharge decision, at least for the purpose of deciding whether the pleadings stated a triable claim.

Having satisfied the condition of proximate cause, the court's determination of whether Western Medical's payment denial was a substantial factor in Wilson's death then depended on the second condition of cause, causation in fact. Would Wilson not have committed suicide if he had been hospitalized as his doctor had wanted? His doctor had testified that "it was reasonably probable to assume that there was a 'reasonably [sic] medical probability' that [Wilson] would have been alive if his hospital stay had not been prematurely terminated."⁷⁷ This was sufficient for the court to conclude that there was "a triable issue of material fact as to whether Western Medical's conduct was a substantial factor in causing [Wilson's] death."⁷⁸

From this discussion, it is obvious that by applying the substantial factor test to utilization review payment determinations, the court in *Wilson* greatly

⁷² *Id.* at 667, 271 Cal. Rptr. at 880.

⁷³ *Id.* at 671, 271 Cal. Rptr. at 883.

⁷⁴ RESTATEMENT (SECOND) OF TORTS § 431 (1965), *cited in Wilson*, 222 Cal. App. 3d at 671-72, 271 Cal. Rptr. at 883 (emphasis added).

⁷⁵ *Wilson*, 222 Cal. App. 3d at 672, 271 Cal. Rptr. at 883.

⁷⁶ *Id.*

⁷⁷ *Id.* at 669-70, 271 Cal. Rptr. at 882.

⁷⁸ *Id.* at 672, 271 Cal. Rptr. at 883.

expanded the potential liability of reviewers over that indicated in *Wickline*. Although the court in *Wilson* was careful to distinguish *Wickline*, the difference in result between the two cases seems due as much to a change in outlook by the court as to a narrow legal distinction. The court in *Wickline* took a dim view of utilization review liability, preferring to hold treating physicians responsible for the care of their patients. In *Wilson*, however, the court seemed to view utilization review much more favorably (at least for the purpose of ruling on a motion for summary judgment). Which of these two views of utilization review liability is wiser is, of course, ultimately a question of policy, not law.⁷⁹

IV. DIRECT V. INDIRECT LIABILITY

In general, utilization review activities can be performed either by the third-party payor itself or by an independent review organization that has contracted with the third-party payor to perform review activities. If the third-party payor performs review and makes payment decisions itself (as Medi-Cal did in *Wickline*), then it will of course be directly liable to the patient if its denial of payment is found to be negligent.

The situation is somewhat different, however, when the payor has contracted with a separate entity (as California Blue Cross had done with Western Medical Review in *Wilson*). In that case, the independent review organization will be directly liable to the patient if the payment denial was made negligently. The payor, on the other hand, will try to argue that the reviewer is an *independent contractor*, and, therefore, the payor should not be held liable for the reviewer's negligence.⁸⁰

However, the payor may still be *indirectly* liable to the patient, under several theories. Under one theory, the payor could be held liable if it was negligent in selecting the independent contractor. According to section 411 of the Restatement (Second) of Torts:

An employer is subject to liability for physical harm to third persons caused by his failure to exercise reasonable care to employ a competent and careful contractor (a) to do work which will involve a risk of physical harm unless it is skillfully and carefully done⁸¹

⁷⁹ See *infra*, notes 110-17 and accompanying text.

⁸⁰ Section 409 of the RESTATEMENT (SECOND) OF TORTS states that except as provided for in other sections of the Restatement, "the employer of an independent contractor is not liable for physical harm caused to another by an act or omission of the contractor or his servants." RESTATEMENT (SECOND) OF TORTS § 409 (1965).

⁸¹ *Id.* at § 411.

As utilization review clearly involves a risk of harm to patients if it is not done skillfully and carefully, the payor may be liable if it selects incompetent or unqualified entities to perform utilization review for it.⁸²

The payor may also be liable under the principle of ostensible agency or apparent authority if the payor's conduct makes it reasonably apparent to the patient that the reviewer is acting as the agent of the payor.⁸³ It has been suggested that payors may avoid this liability by clearly stating in their policies that the reviewer is separate and independent.⁸⁴ However, courts may be likely to hold payors liable anyway, as the most important fact the patient "knows" is that the reviewer has informed him that, based on its recommendation, the payor will not pay for treatment.

V. POTENTIAL BARRIERS TO LIABILITY

Even though the *Wilson* case makes it appear that the liability exposure for utilization reviewers is great, two potential barriers to utilization review liability may narrow liability considerably in actual practice. One is the doctrine of governmental immunity, which may come into play when the reviewer or payor is a governmental entity.⁸⁵ The other is the Employee Retirement Income Security Act of 1974 (ERISA), which preempts state law tort claims against employer self-funded health benefits plans.⁸⁶

A. Governmental Immunity

Governmental immunity becomes an issue when the payor who has reviewed and denied the claim in question is a governmental entity. The major government payors in the United States are the federal Medicare program and the state Medicaid programs.

Utilization review under the federal Medicare program is conducted by Peer Review Organizations (PROs). With a few exceptions, the PROs' review is mainly retrospective, and is concerned with monitoring the quality of care as

⁸² It can be said that the risk of harm resulting from incompetently performed utilization review is clearly "foreseeable," and where there is "a foreseeable risk of harm to others unless precautions are taken, it is [the employer's] duty to exercise reasonable care to select a competent, experienced, and careful contractor" PROSSER & KEETON, *supra* note 7, at 510.

⁸³ See RESTATEMENT (SECOND) OF AGENCY §§ 8, 27 (1958).

⁸⁴ Helvestine, *supra* note 9, at 190.

⁸⁵ See *infra* notes 87-93 and accompanying text.

⁸⁶ See *infra* notes 94-109 and accompanying text.

well as the necessity and appropriateness of care.⁸⁷ Because PRO review is mainly retrospective, Medicare review liability concerns are not great.

Utilization review under Medicaid, on the other hand, is left up to the individual states, and is generally "conducted under the auspices of a state agency with authority to approve or deny claims . . ."⁸⁸ Since states have some discretion in setting up their Medicaid programs, those who choose to utilize prospective review, as California has under its Medi-Cal program, may open themselves up to liability.

Section 895B of the Restatement (Second) of Torts states that:

(1) A State and its governmental agencies are not subject to suit without the consent of the State.

....

(3) Even when a State is subject to tort liability, it and its governmental agencies are immune to the liability for acts and omissions constituting

....

(b) the exercise of an administrative function involving the determination of fundamental governmental policy.⁸⁹

The comment to this section of the Restatement notes that "in practically ever [sic] State consent to suit has been given, to a greater or lesser degree."⁹⁰ Whether, and to what extent, tort liability for this type of suit has been allowed will vary by state.

However, even if consent to tort liability has been given, the state Medicaid entity may still be immune if its payment determination is considered "the exercise of an administrative function." Although the Restatement's requirement that the act involve "*fundamental governmental policy*" would seem difficult to meet as to payment decisions involving *individual* patients, sometimes the issue is phrased in terms of whether the act involved is *discretionary* or merely *ministerial* in nature.⁹¹ The California Government Code, for example, provides that when broad discretionary powers are

⁸⁷ See Politser, *The PRO Utilization and Quality Review Process: An Overview—Part I*, AM. COLLEGE OF SURGEONS BULL., May 1989, at 17; Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 HOUS. L. REV. 191, 194-97 (1989).

⁸⁸ Blum, *supra* note 87, at 197.

⁸⁹ RESTATEMENT (SECOND) OF TORTS § 895B (1965).

⁹⁰ *Id.* § 895B comment a.

⁹¹ Although the issue is sometimes phrased in this way, the discretionary ministerial distinction may not be particularly useful. It has been pointed out that the discretionary—ministerial distinction is "nearly impossible to apply in practice in a consistent manner," for "[e]ven acts that are ministerial usually require decisionmaking on some minor points." L. FRUMER, R. BENOIT, & M. FRIEDMAN, PERSONAL INJURY § 2.03 (1988).

conferred upon a public employee, both the employee and the public entity that employs him are immune from liability.⁹²

It could be argued that a state Medicaid physician reviewer exercises discretion in reviewing patient claims, and, therefore, that state Medicaid programs should be immune from liability.⁹³ Of course, equally strong arguments can be made that the acts of state Medicaid physician reviewers are merely ministerial, carrying out the policies prescribed by statute. Therefore, the issue of whether state Medicaid agencies are immune from liability is far from clear.

B. ERISA Pre-Emption of State Tort Law Claims

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA) in order to "protect . . . the interests of participants in employee benefit plans and their beneficiaries"⁹⁴ ERISA applies to any employee benefit plan that is "*established or maintained . . . by any employer engaged in commerce or . . . by any employee organization or organizations representing employees engaged in commerce or . . . by both.*"⁹⁵ ERISA applies to both employee pension benefit plans and employee welfare benefit plans,⁹⁶ and includes in its definition of employee welfare benefit plans any employee benefit plan that provides "for its participants or their beneficiaries . . . medical, surgical, or hospital care or benefits"⁹⁷

Because one of the ways in which Congress intended to protect participants in employee benefit plans was by "eliminating the threat of conflicting and inconsistent state and local regulation,"⁹⁸ ERISA contains a very broad pre-emption clause, which states: "Except as provided in subsection (b) of this section, the provisions of [ERISA] shall supercede any and all State laws insofar as they . . . *relate to* any employee benefit plan"⁹⁹ A subsequent section of ERISA qualifies the pre-emption clause by exempting from pre-

⁹² CAL. GOV'T. CODE §§ 820.2, 815.2(b) (West 1980), *cited in* Note, Wickline v. State: *The Emerging Liability of Third Party Health Care Payors*, 24 SAN DIEGO L. REV. 1023, 1028 (1987).

⁹³ In fact, Medi-Cal raised the defense of discretionary immunity in *Wickline*, arguing that it was immune under CAL. GOV'T CODE § 820.2, but the court of appeals did not discuss the issue. *Wickline v. State*, 192 Cal. App. 3d 1630, 1643, 239 Cal. Rptr. 810, 817 (1986).

⁹⁴ 29 U.S.C. § 1001(b) (1982).

⁹⁵ 29 U.S.C. § 1003(a) (1982) (emphasis added).

⁹⁶ 29 U.S.C. § 1002(3) (1982).

⁹⁷ 29 U.S.C. § 1002(1) (1982).

⁹⁸ 120 CONG. REC. 29,197 (1974) (statement of Rep. Dent), *cited in* *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983).

⁹⁹ 29 U.S.C. § 1144(a) (1982) (emphasis added) (the "pre-emption" clause).

emption state laws that regulate insurance, banking, and securities.¹⁰⁰ However, another section of ERISA goes on to state that employee benefit plans are deemed *not to be insurance companies* for the purposes of interpreting state laws regulating insurance.¹⁰¹ Therefore, ERISA-qualified employee health benefit plans *are* covered by ERISA's pre-emption clause, and *are exempt* under ERISA from state laws that "relate to" employer benefit plans.

Is a negligence claim against an employee health benefit plan a state law *relating to* an employee benefit plan such that it is, therefore, pre-empted by ERISA? In general, the answer is probably yes. ERISA's pre-emption clause originally was to apply only to those state laws that "[related to] the specific subjects covered by ERISA"; however, that provision was rejected prior to ERISA's enactment in favor of the "relate to" language.¹⁰² This would indicate that Congress intended ERISA's pre-emption clause to be read very broadly.¹⁰³

In fact, the United States Supreme Court has interpreted the ERISA pre-emption clause broadly. Interpreting ERISA's pre-emption clause in *Shaw v. Delta Air Lines, Inc.*, the Court held that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a *connection with* or reference to such a plan."¹⁰⁴ In *Pilot Life Ins. Co. v. Dedeaux*,¹⁰⁵ the Court held that Dedeaux's common law claims of tortious breach of contract, breach of fiduciary duties, and fraud in the inducement against Pilot Life, the insurance company from whom Dedeaux's employer had purchased a group insurance policy¹⁰⁶ to establish an employee disability benefit plan, were pre-empted by ERISA because they "related to" an employee benefit plan.¹⁰⁷ The Court also held "that in order to regulate insurance [and, therefore, be saved from the application of ERISA's pre-emption clause], a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry."¹⁰⁸

Common law claims of negligence against an employee health benefit plan for negligent denial of payment clearly "have a connection" with the plan; they also are not "specifically directed" toward the insurance industry. Following

¹⁰⁰ 29 U.S.C. § 1144(b)(2)(A) (1982) (the "saving" clause).

¹⁰¹ 29 U.S.C. § 1144 (b)(2)(B) (1982) (the "deemer" clause).

¹⁰² *Shaw*, 463 U.S. at 98.

¹⁰³ *Id.*

¹⁰⁴ *Id.* at 96-97 (emphasis added).

¹⁰⁵ 481 U.S. 41 (1987).

¹⁰⁶ Employee benefit plans may provide coverage for participants and their beneficiaries by either purchasing insurance or self-insuring. See Note, *ERISA—Pre-emption—Pilot Life Insurance Co. v. Dedeaux: Congress's Cue to Reassess ERISA's Pre-emptive Effect*, 36 KAN. L. REV. 611, 615 n.42 (1988).

¹⁰⁷ *Pilot Life*, 481 U.S. at 47.

¹⁰⁸ *Id.* at 50.

the reasoning of *Shaw* and *Pilot Life*, then, it is logical to assume that state common law negligence claims against employee benefit plans are pre-empted by ERISA, and in fact most courts "have accorded great deference to the ERISA pre-emption by disallowing state-law claims in tort . . . that concern employer sponsored health benefit plans."¹⁰⁹

Because governmental immunity may insulate governmental payors from liability (depending on the extent to which the governmental entity has waived its immunity), and because participants in employee sponsored health benefit plans and their beneficiaries are precluded from bringing negligence actions against their plans under ERISA's pre-emption clause, the scope of negligent utilization review liability may in reality be much narrower than *Wilson* suggests.

VI. CONCLUSION

Utilization review is a promising tool that insurers, both public and private, are using with greater frequency to help them combat their spiraling health care costs. However, they should be aware that, when applied prospectively, utilization review could expose them to potential negligence liability. This area of the law, like utilization review itself, is young and still developing, however, and the scope and extent of liability are still unclear. Indeed, as this Note has discussed, the two leading cases in this area present two very different views on third-party payor liability for negligent utilization review. *Wickline v. State of California*¹¹⁰ took a rather narrow view of third-party payor liability, holding that, in most cases, the patient's own physician has the "ultimate responsibility" for the patient's care.¹¹¹ *Wilson v. Blue Cross of Southern California*,¹¹² on the other hand, viewed third-party payor liability more broadly, holding that payors should be held liable when their negligent review is a "substantial factor" in the patient's harm.¹¹³

Which of these two views is more sound? As a practical matter, *Wilson* seems to be a better decision. There are at least two good reasons why third-party payors should be held liable for negligent review decisions. One is that it would not be fair to allow third-party payors to intrude into the doctor-patient relationship and perhaps interfere with medical decisionmaking, and at the same time allow payors to escape liability for their negligence on the grounds that the doctor, not the payor, had the "ultimate responsibility" for the patient. Having invited themselves to the dance, third-party payors should be made to

¹⁰⁹ Blum, *supra* note 87, at 202.

¹¹⁰ 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (1986).

¹¹¹ See *supra* notes 21-51 and accompanying text.

¹¹² 222 Cal. App. 3d 660, 271 Cal. Rptr. 876 (1990).

¹¹³ See *supra* notes 52-78 and accompanying text.

face the music when things go wrong. The other reason third-party payors should be held liable for their negligence is that it makes little sense for payors to say that their determinations result only in a denial of payment, not a denial of treatment, and therefore, their determinations are not a factor in the patient's harm if the patient subsequently decides to forego treatment. Realistically, many patients *have no choice but to forego treatment* if payment is denied, as they cannot pay for the treatment out of their own pockets; for them, denial of payment is the deciding factor in the decision to forego treatment.¹¹⁴

As more courts begin to consider the matter, they may struggle because of the fundamental tension between the goals of utilization review (to contain costs and thereby reduce the burden *on society* of health care spending) and the goals of the tort system (to compensate *individuals* for the harms they have suffered).¹¹⁵ Courts may differ in the extent to which they recognize utilization review liability depending on which goals they consider most important.

Courts primarily interested in the broad societal goal of cost containment will probably protect review organizations by recognizing either no liability or only narrow liability (as in *Wickline*), while courts concerned with protecting individual plaintiffs will be more likely to recognize broad liability (as in *Wilson*). Viewed in this manner, the determination of utilization review liability seems to be more a question of policy than of law. Perhaps the issue of utilization review liability should ultimately be left up to the state legislatures, rather than the state courts, to decide.¹¹⁶

At any rate, the issue is certain to arise with greater frequency as utilization review becomes more common, and more and more patients harmed by a

¹¹⁴ The facts in *Wilson* vividly illustrate how little choice people sometimes have when payment is denied. *See supra* notes 52-56 and accompanying text.

¹¹⁵ There has been some debate in the literature over whether or not physicians who operate under cost containment constraints (such as HMO staff physicians) should be held to a *modified* standard of care that takes cost constraints into account. *See, e.g., Hall, The Malpractice Standard Under Health Care Cost Containment*, 17 LAW, MED. & HEALTH CARE 347 (1989); Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719 (1987).

It has been said that "[t]ort liability is an unwieldy tool of social policy in this context [cost containment]. Although it may advance the policy of compensating injuries, it undermines the objective of containing health care expenditures" Note, *Safe Harbor for Health Care Cost Containment*, 43 STAN. L. REV. 399, 421 (1991).

¹¹⁶ Although this Note has primarily discussed how courts might apply negligence liability to review organizations, remember that legislatures can also step into this area. For example, Louisiana has enacted a statute that provides that utilization reviewers will be liable only for damages (limited to physical injury) resulting from unreasonable delay (as defined in the statute), denial or reduction of medically necessary services. LA. REV. STAT. ANN. § 22:657 (West Supp. 1991).

payment denial decision feel, as Mrs. Wickline did, that they are "victims of the system."¹¹⁷

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¹¹⁷ Carlova, *supra* note 30, at 83.